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Covered Events

The newsletter of the Insurance Law Committee

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Committee Leadership

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From the Publications Chair

By Timothy H. Wright

Although Punxsutawney Phil has predicted an early spring, temperatures here in Chicago remain quite cold. If you find yourself in similar climes, I recommend opening up this month's edition of *Covered Events* to bask in the warm glow of coverage analysis, insights and practice tips from fellow insurance practitioners across the country. Thank you to all of our contributors and especially to Kurt Zitzer, Pablo Caceres, Timothy Englebrecht, Yonit Rosengarten, and Fay Ryan for authoring this month's "featured articles."

For many, winter can feel endless, but don't forget that the Insurance Coverage and Claims Institute will be here before you know it, on April 1–3, 2020, in Chicago. The brochure and registration information is available here or at www.dri.org/education-cle.

In addition to excellent seminars like the Insurance Coverage and Claims Institute, our committee also offers an amazing array of top-quality publications. Many of them are available online through LegalPoint, or through the DRI app, and DRI members can easily search and read articles online. For authors, online content means more opportunity to get our names out there. Contributing to publications is just as much a DRI and ILC membership benefit as receiving and reading them. We encourage you to join one of the ILC's many substantive law groups so that you learn of opportunities to write, and to let the ILC publications chairs and editors know of your interest. Each year, we produce twelve issues of *Covered Events*, two dedicated issues of *For The Defense*, two dedicated issues of *In-House Defense Quarterly*, three columns for *The Voice*, and one to two 50-state surveys of key issues in coverage and bad faith law.

Covered Events

The ILC's flagship publication, *Covered Events*, contains articles discussing key trends in insurance law and practical tips. Articles are between 3,000 to 5,000 words and feature national research. We also publish short summaries of recent cases and new statutes of importance. For questions about publications standards and formatting, contact Suzanne Whitehead, our *Covered Events* editor in chief, at swhitehead@skarzynski.com, or the *Covered Events* editors, Lindsay Rollins at lrollins@hancockdaniel.com, Mike Pursell at mpursell@gordonrees.com, or Albert Alikin at aalikin@goldbergsegalla.com. To be considered to contribute, please join a substantive law group (ILC subcommittee) so that you are on the list of people solicited for content, or contact one of the *Covered Events* associate editors, Robert Friedman at rfriedman@hccw.com, Landon Greene at lgreene@goldbergsegalla.com, Blake Hunter at jhunter1@butler.legal, and Regen O'Malley at romalley@grsm.com.

For The Defense

FTD is DRI's monthly magazine. The ILC's dedicated issues appear in May and October each year. The content consists of longer articles with a practical focus. These are excellent works that go out to DRI's entire membership. We solicit article proposals each spring and December. Contact Kelly Lippincott, the ILC's editor for FTD, at klippincott@grsm.com, or the ILC's associate editors for *FTD*, Courtney Britt at cbritt@teaguecampbell.com, or Tanya Austin at taustin@bsctrialattorneys.com.

In-House Defense Quarterly

IDQ is DRI's magazine geared to in-house counsel, including insurance company professionals. The ILC's dedicated issues appear in Spring and Fall each year. We solicit article proposals each spring and December. Contact Rosa Tumialán, the ILC's editor for *IDQ*, at rtumialan@dykema.com, or the ILC's associate editor for IDQ, Meghan Ruesch at mruesch@lewiswagner.com.

The Voice

The Voice is DRI's weekly e-newsletter, and it reaches the entire DRI membership. The ILC contributes three articles each year. To submit a proposal, contact the ILC's editors for *The Voice*, Bryana Blessinger at BryanaBlessinger@MarkowitzHerbold.com or Diane Davis at ddavis@ffllp.com.

Compendia

Our compendia, part of DRI's Defense Library Series, address the current state of the law on selected topics in insurance and bad faith law in each of the 50 states and

other jurisdictions, written in either survey or essay format. They are indispensable resources for insurance attorneys. Recent compendia are available in LegalPoint. Brandon McCullough is our compendium chair. He maintains a current list of ILC members who are interested in contributing, either by serving as editors or researching and authoring chapters. If you have an idea for a compendium topic and/or would like to be considered to contribute, please provide your information to Elaine and Brandon so that we can contact you regarding opportunities. His email is mccullloughb@hh-law.com.

Publications Marketing

We want everyone to know about our outstanding publications, and for our authors to promote their contributions as well as DRI and the ILC! Mike Mills works with all of our editors, chairs and authors to ensure that we get the word out to our members, friends, colleagues and industry personnel. Contact Mike at mmills@blwmlawfirm.com if you have any questions about our publications marketing initiatives.

Please contact me if you have a topic idea but are not sure what the best forum for publication is, or if you have any questions or suggestions about the ILC's publications program.

Tim Wright's practice focuses on complex insurance coverage and bad faith issues. Tim's practice is nationwide in scope, and he advises his clients from his office in Chicago, Illinois, where he is a partner at Skarzynski Marick & Black LLP.

From the Excess & Umbrella Chair

By Fay E. Ryan

The Excess and Umbrella Substantive Law Group (EUSLG) has been working tirelessly, but not to the point of exhaustion. We don't concede "exhaustion" without a fight. Not when the ILC has committed to the publication of multiple "occurrences" of *Covered Events*. We are instead calling for reinforcements by holding a membership drive. If you would like to join our subcommittee, please contact me at fryan@butler.legal. We can find an attachment point to trigger your interest.

Our focus group is dedicated to deconstructing the developing law on those issues of special import to excess and umbrella insurers, including good faith exhaustion, method of exhaustion (horizontal vs. vertical), allocation of indemnity for long-tail claims, the number of "occurrences" posed by a related series of events, and an excess insurer's right of recourse, if any, against deficient defense counsel retained by the primary insurer. This is an exciting and challenging time to be a member of the excess and umbrella community, particularly "high-level excess," in light of the upward trend of "mass litigation" potentially triggering "towers of coverage" in the many millions of dollars. In addition to mass shootings, talc claims, and the Round-Up litigation, we are seeing creative new lawsuits. These include the nascent litigation against the major hotel chains brought by sex workers contending that the hotels had a duty to detect and prevent purported "trafficking" operations taking place behind closed doors. Up next in the cross hairs could be national youth organizations which, as a result of states rolling back statutes of limitation, may find themselves sued by multiple generations of childhood sex abuse victims, some of whom are now senior citizens. Is the Boy Scout bankruptcy just the tip of the iceberg?

If you are drawn to these topics or others, or would like to contribute a "Featured Article," case comment, or blog post, please put us on notice as soon as practicable.

A partner at Butler Weihmuller Katz Craig LLP, Fay E. Ryan devotes her Tampa practice to Third-Party Coverage and Extra-Contractual matters. Within these practice areas, her numerous claims deal with construction defect, auto accidents, slip-and-falls, products liability, defamation, and more. Fay has experience analyzing virtually all types of liability policies, including CGL, Excess and Umbrella, OCIP, Commercial Auto, Personal Lines, E & O, Environmental, and Reinsurance. In addition to providing coverage advice, Fay advises clients on good faith claims handling, including settlement in multi-claimant situations. Fay has tried over fifty jury trials and approximately thirty non-jury trials .

Featured Articles

When Claims and Potential Claims May Intersect in Claims Made Coverage

By Kurt Zitzer

The essence of claims made coverage is that a claim must be "first made" during the policy period in order for the risk to attach to the policy. It is generally understood that unlike an occurrence policy—where the timing of the accident giving rise to the injury is the temporal triggering event for coverage—in claims made coverage the temporal event is when the claim against the insured is "first made." Accordingly, it is the policy in effect when the claim is first made that responds to the risk. Courts routinely enforce this aspect of coverage, and cite to the underwriting assumptions resulting therefrom, to uphold this essential element of claims made coverage. *See Helfand v. Nat'l Union Fire Ins. Co.*, 10 Cal. App. 4th 869 (1992). This article will explore the issue of when facts may cloud the question of when a claim was "first made," and the intersection of policy provisions that require an insured to put a carrier on notice of a "potential claim" or exclude coverage for an insured's prior knowledge of facts that would reasonably result in the making of a future claim.

Traditionally, claims made coverage is most often issued in the context of professional liability. A typical professional liability policy's insuring agreement may read something like this:

"This policy applies to "claims" first made against the insured during the policy period for a "wrongful act" of the insured in the rendering or failure to render a "professional service'."

In order for the insuring agreement to be met, a claim, typically defined as "a demand for money or services," must be first made against the insured during the policy period. Some courts more generally define a claim in this context as "an assertion of a legally cognizable damage… that can be defended, settled and paid by the insurer." *See Evanston Ins. Co. v. GAB Business Services, Inc.*, 521 N.Y.S.2d 692, 695 (N.Y. App. Div. 1987). The question sometimes arises of "when was the claim first made"? Aside from temporal considerations, the language of the policy may help answer this question.

In *Kantrud v. Minnesota Lawyers Mut. Ins. Co.,* No. A19-0628 (Minn. App. Nov. 25, 2019), the Minnesota Court of Appeals took up the question of whether the carrier had a duty to defend the insured attorney under a claims made policy where summary judgement was previously granted against Minnesota Lawyers Mutual ("MLM") based upon the trial court's finding that the claim was deemed first made during the policy period. In the policy at issue, the definition of when a claim is made provided as follows:

> (1) a demand is communicated to an INSURED for DAMAGES resulting from the rendering of or failure to render PROFESSIONAL SERIVCES, or
>
> (2) an INSURED first becomes aware of any actual or alleged act, error or omission by any INSURED which could reasonably support or lead to a CLAIM.

Id.

The language in the *Kantrud* case is admittedly unique, in that the definition of claim incorporates the concepts of both traditional claims and "potential claims" as typically defined in professional liability policies and/or the notion of exclusionary language for "prior knowledge." In many claims made policies, the language of the policy will allow an insured to provide the carrier with knowledge of facts and circumstances that may reasonably lead to the making of a future claim. *See Farm Bureau Life Ins. Co. v. Chubb Custom Ins. Co.*, 780 N.W.2d 735 (Iowa 2010). Additionally, a common exclusion of coverage applies to prior knowledge of the existence of circumstances that may reasonably lead to the making of a claim. *See James River Ins. Co. v. Hebert Schenk, P.C.*, 53 P.3d 915 (9th Cir. 2008). In the case we are examining, the particular policy stated that a claim is "deemed" first made upon: (1) a demand, *or* (2) the insured becoming aware of facts or circumstances that could reasonably support a future claim. It is this unique language in the MLM policy that provides a good source to analyze the intersection of claims made coverage with prior knowledge of a potential claim.

In the policy at issue, the carrier made no distinction, in the definition of claim, between an actual demand for money or services and an insured being aware of facts or circumstance that would reasonably lead to the making of a future demand. In other words, the policy made no distinction between claims and potential claims. On appeal,

MLM unsuccessfully argued that the facts of the case demonstrated that the claim was "deemed" first made prior to the issuance of its policy. The Minnesota Court of Appeals affirmed judgment in favor of the insured.

Since 2010, MLM had insured Kantrud under a claims made lawyer's professional liability policy. Kantrud renewed his insurance with a new policy effective July of 2016. In November of 2016, months after his prior policy had expired, he reported a claim days after his former clients sued him for malpractice. The suit alleged that in 2014 and 2015, Kantrud, acting as a collection attorney, had negligently missed discovery deadlines and ignored court orders, resulting in the district court entering a default judgment against the clients.

MLM denied coverage to Kantrud on the basis that he did not report the claim until after the clients brought suit despite being aware of facts and circumstances the could "reasonably support" a malpractice claim before he renewed his policy in July of 2016. In other words, MLM argued that Kantrud was obligated to report the claim under his prior policy based upon the definition of claim that included potential claims. MLM's position was that the claim was "deemed made" as early as at least 2015 when Kantrud became aware that his alleged actions (or inaction) had resulted in a default judgment against his clients. In rejecting this argument, both the trial court and court of appeals held that under Minnesota's duty to defend standard, the undisputed facts did not conclusively establish that all reasonable attorneys would have anticipated a future malpractice suit.

In characterizing the policy's definition of claim, the court held that one of two events must be present:

> (1) the insured is subjectively aware of an actual demand for damages; or (2) the insured is subjectively aware of acts or omissions that could objectively support a future claim for damages.

Kantrud, *supra*, note 5. In characterizing the second prong of the definition of claim, the court read into the clause the typical subjective-objective test applied in most "prior knowledge" circumstances. Under such a test, the carrier has the burden to show the insured was subjectively aware of facts that would objectively cause a reasonable insured to believe a claim against them may exist. *See Selko v. Home Ins. Co.*, 139 F.3d 146 (3rd Cir. 1998). Applying this standard to the duty to defend, the court noted that under Minnesota law, if a carrier is aware of facts outside the complaint "which *conclusively establish*" that there is no coverage; the insurer has no duty to defend. *Id.* (citing *St. Paul Fire & Marine Ins. Co. v. Nat'l Comput. Sys., Inc.*, 490 N.W.2d 626, 632 (Minn. App. 1992)).

In the underlying action, the complaint for malpractice alleged Kantrud had committed malpractice by failing to respond to discovery in 2014 and 2015. Also attached to the complaint was an affidavit Kantrud had filed in the underlying action essentially admitting he "was responsible for all deficiencies in discovery production that eventually led to the default judgment." *Id.* We might expect that information would be have been sufficient for a court to find a claim was made prior to the 2016 policy period, but both the trial court and court of appeals disagreed and held that MLM owed a duty to defend.

The *Kantrud* court held that the entirety of the record failed to *conclusively establish* that Kantrud was aware of facts that would objectively cause a reasonable insured to believe a claim would be made. The court examined other aspects of the record, including the trial court's order in the underlying litigation where the default judgment was entered. The court cited to the appellate decision contesting the default wherein the appellate court held:

> [T]he record does not conclusively establish that the [defendants] were innocent in failing to adequately and timely respond to First American's discovery requests. This is especially the case given that [one of the defendants] is an attorney, and the fact the [Kantrud's client] signed discovery responses that were deemed inadequate by the district court.

See First Am. Title Ins. Co. v. Nat'l Title Res. Corp., 2016 WL 363477, *4 (Minn. App. 2016). Accordingly, the *Kantrud* court held that the record did not conclusively establish Kantrud was objectively aware of facts that would cause a reasonable insured to believe a claim would be made.

The outcome of this case is troublesome given what appears to be solid evidence that before the 2016 policy was issued; 1) the insured committed an act, error or omission that led to a judgment being entered against his client, and 2) that the insured admitted in an affidavit that it was his fault. This causes the need to make a couple of observations. First, perhaps the outcome would have been different if the limiting language would have been located in an exclusion rather than in the definition of claim. However, it is also unclear the carrier would have denied a defense based upon a prior knowledge exclusion knowing it bears the burden of proving the exclusion applies. Second, the question of prior knowledge is often a fact intensive inquiry, and this case illustrates that even when the facts appear solid, a court may go out of its way to

find potential coverage. Finally, when addressing the issue of objectively reasonable knowledge of facts giving rise to a claim, the Minnesota court overlaid its "conclusively established" standard over the question of whether it was objectively reasonable for an insured to conclude a claim would be made. By requiring that the facts "conclusively establish" a claim would be made, rather than simply whether it was objectively reasonable to conclude a claim may be made, the court created a burden outside the clear language of the policy.

The unique language of the *Kantrud* policy, where the concept of both an actual and potential claim are woven into coverage by the use of "deemer" language in the definition of claim, provides a good source to analyze the interplay between actual and potential claims. In the end, MLM's attempt to treat both categories in the same fashion in the definition of claim may have proved a bridge too far for the court. But in the final analysis, the case is instructive of the point that when a carrier is analyzing when a claim was first made in the context of the insured's prior knowledge of facts and circumstances, the analysis must be thorough and consider all facts, both favorable and unfavorable to any ultimate conclusion.

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A Revisit of Florida's New Assignment of Benefits Law

By Pablo Caceres and Timothy Englebrecht

States suffering from recent CAT losses continue to face many claims presented through assignments of benefits ("AOB"). These assignments purport to assign all or part of a property insurance claim to a remediation or repair company in exchange for work performed or to be performed at the insured property. Such work often includes water mitigation work, as well as roofing work. Controversies arise when the bills for such work appear unreasonable.

Florida was, at least until recently, a perfect storm for these AOBs. The dense population, two major hurricane CAT losses, and favorable insurance law, allowed an AOB vendor to collect assignments from countless insureds in a short period of time and eventually litigate them when insurers refused to pay perceived inflated invoices. Florida's general insurance "fee shifting" statute made insurers liable for attorney fees if the AOB vendor collected even a dollar more than previously paid. A quick review of case law involving property insurance AOB claims confirms that Florida has been the epicenter for such claims over the past several years.

Last year, the Florida legislature enacted a hopeful fix, attempting to balance the consumer interest in having AOB contracts with the insurance industry's interest in minimizing incentives to presented inflated claims. Florida's new law merits another review. But first, the laws of a few other states vulnerable to CAT losses are worth a quick review.

Texas law, unlike Florida before the new law, allows a policy's anti-assignment clause to prohibit an assignment of an insurance claim. *See ARM Props. Mgmt. Group v. RSUI Indem. Co.*, 642 F.Supp.2d 592, 609–10 (W.D. Tex. 2009) (citing *Tex. Farmers Ins. Co. v. Gerdes*, 880 S.W. 2d 215, 218 (Tex. App. 1994)). This is true even if the non-assignment clause is general and broadly worded. This stifles, of course, the growth of any AOB industry in Texas. An excellent article by Zelle LLP explains that work arounds like a limited power of attorney likely would fail in Texas. Zelle, LLP, *Limited Power of Attorney No Substitute for AOB in Texas*, JD *SUPRA* (Mar. 27, 2018), https://www.jdsupra.com/legalnews/limited-power-of-attorney-no-substitute-93612/.

Louisiana takes a hybrid approach to AOBs. Louisiana allows an insurer to place a clause in an insurance policy that prohibits post-loss assignments. *In re Katrina Canal Breaches Litig.*, 63 So. 3d 955, 962–63 (La. 2011). However, for such a clause to be enforceable, the clause must clearly and unambiguously state that it applies to post-loss assignments. *Id.* The general and broadly worded non-assignment clause contained in many standard insurance policies is not sufficient. *Id.*

Georgia, much like many states across the country, permits AOBs. *See Santiago v. Safeway Ins. Co.*, 196 Ga. App. 480, 481, 396 S.E.2d 506, 608 (App. Ct. 1990). However, a

review of published case law reveals little if any attention given specifically to property insurance AOBs.

North Carolina and South Carolina also allow AOBs. In upholding the validity of an assignment, courts in these states have ruled not only that assignments of benefits are indeed valid, but also, that they are governed by each state's general contract law. *See e.g., Alaimo Family Chiropractic v. Allstate Ins. Co.*, 155 N.C. App. 194, 197, 574 S.E.2d 496, 498 (N.C. Ct. App. 2002); *Gray v. State Farm Auto. Ins. Co.*, 327 S.C. 646, 491 S.E.2d 272 (S.C. Ct. App. 1997). This means that anti-assignment clauses could be effective to prevent a proliferation of AOBs.

California, by statute, prohibits policy bars on post-loss assignments. California Insurance Code §520 provides that "[a]n agreement not to transfer the claim of the insured against the insurer after a loss has happened, is void if made before the loss . . . ." "After a loss has arisen liability is fastened upon the insurer and any right of the insured as a result of the loss may be assigned with or without the consent of the insurer." *Fluor v. Super. Ct.*, 61 Cal. 4th 1175, 1212 (2015).

Florida's New AOB Statute

Florida's new AOB law took effect last July. Citizens Property Insurance Corporation, the insurer of last resort, reported that before the enactment, it received 800 to 900 AOB claims per month. In July, once the reforms took effect, the number was down to 707, followed by 468 in August, 375 in September and 374 in October. Amy O'Connor, Citizens CEO Notes Impact of AOB Reforms as New Rates to Take Effect in Florida, INSURANCE JOURNAL (Nov. 20, 2019). The new law appears to have done what it was meant to do. So it is appropriate to review the law in greater detail to see how this novel legislation appears to have succeeded, at least in the short term.

On April 24, 2019, the Florida Legislature passed a bill (SB 122/HB 7065) that makes significant changes to the assignment of benefits ("AOB") process in Florida. The new law became effective July 1, 2019.

The bill was passed to address concerns regarding abusive litigation practices by contractors and their lawyers. It also was passed to address concerns that insureds were unwittingly losing control over their insurance rights. The bill was intended to help stabilize insurance premiums that were being driven up by the AOB practice.

The legislative changes do not apply to surplus lines insurers because the changes are only in Florida Statutes Chapter 627, which does not apply to surplus lines carriers. See Florida Statute §626.913(4)1. However, it is expected that surplus lines insurers will offer insurance policies that do not allow the assignment of benefits in much the same way admitted insurers are going to be allowed to do. In that sense, it is expected that many of the benefits of the law change will apply equally to both admitted and surplus lines carriers in practice.

The legislative changes appear in Florida Statutes §§627.7152, 627.7153, and 627.422. All three will be addressed in turn below.

Florida Statute §627.7152 has 13 subsections, but only some are merit discussion here.

Subsection 2a

Subsection 2a sets forth requirements for a valid assignment. This is a substantial hoop through which an AOB vendor must jump or else face problems in presenting a valid claim. An assignment agreement must be in writing and executed by and between the assignor and the assignee. It must contain a provision that allows the assignor to rescind the assignment agreement without a penalty or fee by submitting a written notice of rescission signed by the assignor to the assignee within 14 days after the execution of the agreement, at least 30 days after the date work on the property is scheduled to commence if the assignee has not substantially performed, or at least 30 days after the execution of the agreement if the agreement does not contain a commencement date and the assignee has not begun substantial work on the property.

An assignment agreement must contain a provision requiring the assignee to provide a copy of the executed assignment agreement to the insurer within three business days after the date on which the assignment agreement is signed or the date on which work begins, whichever is earlier. Delivery of the copy of the assignment agreement to the insurer may be made by personal service, overnight delivery, or electronic transmission, with evidence of delivery in the form of a receipt or other paper or electronic acknowledgement by the insurer; or to the location designated for receipt of such agreements as specified in the policy.

An assignment agreement must contain a written, itemized, per-unit cost estimate of the services to be performed by the assignee. An assignment agreement must relate only to work to be performed by the assignee for services to protect, repair, restore, or replace a dwelling or structure or to mitigate against further damage to such property.

An assignment agreement must contain the following notice in 18-point uppercase and boldfaced type:

> YOU ARE AGREEING TO GIVE UP CERTAIN RIGHTS YOU HAVE UNDER YOUR INSURANCE POLICY TO A THIRD PARTY, WHICH MAY RESULT IN LITIGATION AGAINST YOUR INSURER. PLEASE READ AND UNDERSTAND THIS DOCUMENT BEFORE SIGNING IT. YOU HAVE THE RIGHT TO CANCEL THIS AGREEMENT WITHOUT PENALTY WITHIN 14 DAYS AFTER THE DATE THE AGREEMENT IS EXECUTED, AT LEAST 30 DAYS AFTER THE DATE WORK ON THE PROPERTY IS SCHEDULED TO COMMENCE IF THE ASSIGNEE HAS NOT SUBSTANTIALLY PERFORMED, OR AT LEAST 30 DAYS AFTER THE EXECUTION OF THE AGREEMENT IF THE AGREEMENT DOES NOT CONTAIN A COMMENCEMENT DATE AND THE ASSIGNEE HAS NOT BEGUN SUBSTANTIAL WORK ON THE PROPERTY. HOWEVER, YOU ARE OBLIGATED FOR PAYMENT OF ANY CONTRACTED WORK PERFORMED BEFORE THE AGREEMENT IS RESCINDED. THIS AGREEMENT DOES NOT CHANGE YOUR OBLIGATION TO PERFORM THE DUTIES REQUIRED UNDER YOUR PROPERTY INSURANCE POLICY.

An assignment agreement must contain a provision requiring the assignee to indemnify and hold harmless the assignor from all liabilities, damages, losses, and costs, including, but not limited to, attorney fees, should the policy subject to the assignment agreement prohibit, in whole or in part, the assignment of benefits.

Subsection 2c

Subsection 2c explains that there is a cap on urgent or emergency services. Subsection 2c states that, if an assignor acts under an urgent or emergency circumstance to protect property from damage and executes an assignment agreement to protect, repair, restore, or replace property or to mitigate against further damage to the property, an assignee may not receive an assignment of post-loss benefits under a residential property insurance policy in excess of the greater of $3,000 or 1 percent of the Coverage A limit under such policy. The term "urgent or emergency circumstance" means a situation in which a loss to property, if not addressed immediately, will result in additional damage until measures are completed to prevent such damage.

Subsection 3

Subsection 3 lists a number of new obligations that now apply to assignees. In a claim arising under an assignment agreement, an assignee has the burden to demonstrate that the insurer is not prejudiced by the assignee's failure to maintain records of all services provided under the assignment agreement; cooperate with the insurer in the claim investigation; provide the insurer with requested records and documents related to the services provided, and permit the insurer to make copies of such records and documents; and deliver a copy of the executed assignment agreement to the insurer within three business days after executing the assignment agreement or work has begun, whichever is earlier.

Subsection 4

Subsection 4 lists a number of additional new obligations that now apply to assignees. An assignee must provide the assignor with accurate and up-to-date revised estimates of the scope of work to be performed as supplemental or additional repairs are required. An assignee must perform the work in accordance with accepted industry standards. An assignee may not seek payment from the assignor exceeding the applicable deductible under the policy unless the assignor has chosen to have additional work performed at the assignor's own expense.

An assignee must, as a condition precedent to filing suit under the policy, and, if required by the insurer, submit to examinations under oath and recorded statements conducted by the insurer or the insurer's representative that are reasonably necessary, based on the scope of the work and the complexity of the claim, which examinations and recorded statements must be limited to matters related to the services provided, the cost of the services, and the assignment agreement. This is a potential game-changer, as the insurer no longer must rely on invoices and other records as justification for the amounts billed.

An assignee must, as a condition precedent to filing suit under the policy, and, if required by the insurer, participate in appraisal or other alternative dispute resolution methods in accordance with the terms of the policy.

Subsection 7a

Subsection 7a explains that, notwithstanding any other provision of law, and except as provided below, acceptance by an assignee of an assignment agreement is a waiver by the assignee and its subcontractors of claims against a named insured for payments arising from the assignment agreement. The assignee and its subcontractors may not collect or attempt to collect money from an insured, maintain any action at law against an insured, claim a lien on the real property of an insured, or report an insured to a credit agency for payments arising from the assignment agreement. Such waiver remains in effect after

the assignment agreement is rescinded by the assignor or after a determination that the assignment agreement is invalid. Releasing the insured from liability for uncollected fees or if the assignment is invalid presents a real risk to AOB vendors.

Subsection 8

Subsection 8 states that the assignee shall indemnify and hold harmless the assignor from all liabilities, damages, losses, and costs, including, but not limited to, attorney fees, should the policy subject to the assignment agreement prohibit, in whole or in part, the assignment of benefits. This is yet another consumer-friendly provision that poses a real risk to an AOB vendor that it could be responsible for an insured's attorney fees.

Subsection 9a

Subsection 9a explains what an assignee must do before commencing a lawsuit. An assignee must provide the named insured, insurer, and the assignor, if not the named insured, with a written notice of intent to initiate litigation before filing suit. Such notice must be served by certified mail, return receipt requested, or electronic delivery at least 10 business days before filing suit, but may not be served before the insurer has made a determination of coverage under Florida Statute §627.70131. The notice must specify the damages in dispute, the amount claimed, and a presuit settlement demand. Concurrent with the notice, and as a precondition to filing suit, the assignee must provide the named insured, insurer, and the assignor, if not the named insured, a detailed written invoice or estimate of services, including itemized information on equipment, materials, and supplies; the number of labor hours; and, in the case of work performed, proof that the work has been performed in accordance with accepted industry standards.

Subsection 9b

Subsection 9b explains what an insurer must do in response to a presuit demand notice from an assignee. An insurer must respond in writing to the notice within 10 business days after receiving the notice by making a presuit settlement offer or requiring the assignee to participate in appraisal or other method of alternative dispute resolution under the policy. An insurer must have a procedure for the prompt investigation, review, and evaluation of the dispute stated in the notice and must investigate each claim contained in the notice in accordance with the Florida Insurance Code.

Subsection 10

Subsection 10 changes the way attorney fees are assessed at the conclusion of AOB litigation. This attorney fee section is the real "game changer." It eliminates the conventional fee-shifting statute as it applies to AOB claims. Notwithstanding any other provision of law, in a suit related to an assignment agreement for post-loss claims arising under a residential or commercial property insurance policy, attorney fees and costs may be recovered by an assignee only under Florida Statute §57.105 and this subsection. Attorney fees are assessed based on a sliding scale depending on the outcome of the litigation.

If the difference between the judgment obtained by the assignee and the presuit settlement offer is less than 25 percent of the disputed amount, the insurer is entitled to an award of reasonable attorney fees.

If the difference between the judgment obtained by the assignee and the presuit settlement offer is at least 25 percent but less than 50 percent of the disputed amount, no party is entitled to an award of attorney fees.

If the difference between the judgment obtained by the assignee and the presuit settlement offer is at least 50 percent of the disputed amount, the assignee is entitled to an award of reasonable attorney fees.

However, if the insurer fails to inspect the property or provide written or oral authorization for repairs within 7 calendar days after the first notice of loss, the insurer waives its right to an award of attorney fees. If the failure to inspect the property or provide written or oral authorization for repairs is the result of an event for which the Governor of Florida had declared a state of emergency under Florida Statute §252.36, factors beyond the control of the insurer which reasonably prevented an inspection or written or oral authorization for repairs, or the named insured's failure or inability to allow an inspection of the property after a request by the insurer, the insurer does not waive its right to an award of attorney fees.

Additionally, if an assignee commences an action in any court of Florida based upon or including the same claim against the same adverse party that such assignee has previously voluntarily dismissed in a court of Florida, the court may order the assignee to pay the attorney fees and costs of the adverse party resulting from the action previously voluntarily dismissed. The court shall stay the proceedings in the subsequent action until the assignee complies with the order.

Subsection 13

Subsection 13 states that this section applies to an assignment agreement executed on or after July 1, 2019. Also, Florida Statute §627.7153 allows insurers to offer policies restricting assignment of post-loss benefits under a property insurance policy. Certain requirements must be met.

An insurer may make available a policy that restricts in whole or in part an insured's right to execute an assignment agreement. However, the insurer must do the following. The insurer must make available to the insured or potential insured at the same time the same coverage under a policy that does not restrict the right to execute an assignment agreement. Each restricted policy must be available at a lower cost than the unrestricted policy. The policy prohibiting assignment in whole is available at a lower cost than any policy prohibiting assignment in part. Each restricted policy must include on its face the following notice in 18-point uppercase and boldfaced type:

> THIS POLICY DOES NOT ALLOW THE UNRESTRICTED ASSIGNMENT OF POST-LOSS INSURANCE BENEFITS. BY SELECTING THIS POLICY, YOU WAIVE 320 YOUR RIGHT TO FREELY ASSIGN OR TRANSFER THE POST-LOSS PROPERTY INSURANCE BENEFITS AVAILABLE UNDER THIS POLICY TO A THIRD PARTY OR TO OTHERWISE FREELY ENTER INTO AN ASSIGNMENT AGREEMENT AS THE TERM IS DEFINED IN SECTION 627.7152 OF THE FLORIDA STATUTES.

Furthermore, the insurer shall notify the insured at least annually of the coverage options the insurer makes available under this section. Such notice must be part of and attached to the notice of premium.

A named insured must reject a fully assignable policy in writing or electronically. The rejection of a fully assignable policy shall be made on a form approved by OIR. The form must state that the policy restricts the assignment of benefits. The heading of the form shall be in 18-point uppercase and boldfaced type and state:

> YOU ARE ELECTING TO PURCHASE AN INSURANCE POLICY THAT RESTRICTS THE ASSIGNMENT OF BENEFITS UNDER THE POLICY IN WHOLE OR IN PART. PLEASE READ CAREFULLY.

This applies to a policy issued or renewed on or after July 1, 2019.

Florida Statutes §627.422 addresses a few other issues implicated by the law change.

Conclusion

Clearly, the statute has addressed key areas of concern, including the one-sidedness of many AOB assignments, problems with AOB billing, the investigation and adjustment of the invoiced charges, pre-suit requirements, and attorney fee recovery. The offering and acceptance of policies with bans on post-loss assignments undoubtedly will significantly reduce AOB claims in the long term. The multi-pronged approach of Florida's new statute appears to be responsible for the substantial reduction in AOB litigation.

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Products-Completed Operations Hazard: When Is Work "Completed" or "Abandoned"?

By Yonit Rosengarten and Fay Ryan

Commercial General Liability Policies ("CGL") Policies "commonly differentiate between the insured's ongoing operations and those that have been completed or abandoned, especially in relation to the application of the business risk exclusions." 9A Couch on Ins. §129:25. The "business risks" exclusions in the standard CGL Policy are generally effective to bar coverage for most "property damage" to the insured's work that occurs while the work is ongoing. Exclusions J(5) and J(6) work in tandem to bar coverage for incomplete, defective work. Exclusion

J(5) bars coverage for any "property damage" to that particular part of real property on which the insured, or any subcontractors working directly or indirectly on the insured's behalf *are performing* operations, if the "property damage" arises out of those operations. The Damage to Property J(6) Exclusion bars coverage for any "'property damage" to that particular part of any property that must be restored, repaired, or replaced because the insured's "work" was incorrectly performed on it. Critically, Exclusion J(6) does not apply to "property damage" included in the "products-completed operations hazard" or "PCOH." This begs the question – what is the products-completed operations hazard?

Some courts have determined that the products-completed operations hazard provision "does not create distinct coverage separate and apart from the delineated coverage portions of the policy." *Sparta Ins. Co. v. Colareta*, 990 F.Supp.2d 1357, 1365 (S.D. Fla. 2014); *but see Owners Ins. Co. v. Jim Carr Homebuilder, LLC*, 15 So. 3d 148 (Ala. 2014) (holding that the Damage to Your Work Exclusion in the insured's CGL Policy, which bars coverage for the insured's defective and completed work, did not bar coverage for construction defect claims even though the insured's operations were completed at the time of the alleged occurrence because the Damage to Your Work Exclusion is only applicable if the policy's declaration failed to show coverage for products-completed operations and the insured's CGL policy provided $4 million in coverage for the insured's products-completed operations).

These courts have noted that while Coverage A (Bodily Injury and Property Damage Liability), Coverage B (Personal and Advertising Injury Liability), and Coverage C (Medical Payments) all contain their own insuring agreement and exclusions, the products-completed operations hazard is only listed in the Policy's "Definitions" section and is not designated as a type of coverage. *Sparta*, 990 F.Supp.2d at 1365. Accordingly, "any claim falling under the definition of 'products-completed operations hazard' is subject to the terms and limitations of the coverage portion to which it applies." *Id.*; *see also generally Paradigm Ins. Co. v. Texas Richmond Corp.*, 942 S.W.2d 645, 652 (Tex. Ct. App. 1997) ("Upon review of the terms of the policy, it is clear that the coverage for hazards arising out of Products/Completed Operations is merely a part of the coverage provided under the Commercial General Liability Coverage. There is no provision of coverage other than under the Commercial General Liability Coverage, and there is not a separate grant of coverage for Products/Completed Operations Hazard.").

Courts have additionally determined that "the purpose of the products-completed operations hazard coverage is to insure against the risk that the product or work, if defective, may cause bodily injury or damage to property of others after it leaves the insured's hands." *Baker v. National Interstate Ins. Co.*, 103 Cal.Rptr.3d 565, 579 (Cal. Ct. App. 2009) (citing *Goodwin v. Wright*, 6 P.3d 1, 4 (Wash. Ct. App. 2000)). This purpose also explains the standard CGL policy's subcontractor exception to the Damage to Your Work Exclusion, which bars coverage for the insured's own defective work. Work which was performed on the insured's behalf by a subcontractor was not in the "hands" of the insured when performed. Accordingly, the subcontractor exception restores coverage to the insured for completed and defective work, which was performed by a subcontractor on the insured's behalf. It is the "risk of injury to persons or property *other than the contractor's work or product* that is addressed by commercial liability policies." §18:2. Exclusions-Your work and the products/completed operation hazard, 35 Wa. Prac., Washington Insurance Law and Litigation §18:2 (2019-2020 ed.) (emphasis added). The purpose of the products-completed operations hazard provision therefore suggests that a CGL policy is not intended to protect the insured from its own defective incomplete or completed work. After all, the term "completed" is in the title of the "products-*completed* operations hazard."

The standard CGL policy defines "property damage" as "physical injury to tangible property, including all resulting loss of use of that property" or "the loss of use of tangible property that is not physically injured." The standard CGL policy defines the insured's "work" as: (1) any work or operations performed by the insured or on the insured's behalf; and (2) materials, parts, or equipment furnished in connection with such work or operations. The insured's work also includes: (1) warranties or representations made at any time with respect to the fitness, quality, durability, performance or use of the insured's "work"' and (2) the providing of or failure to provide warning or instructions.

The standard CGL policy specifies that the "products-completed operations hazard" includes all "property damage" that occurs away from premises owned or rented by the insured and that arises out of the insured's work or product *except for*: (1) products that are still in the insured's physical possession; or (2) work that has not yet been completed or abandoned. The insured's work is deemed completed at the earliest of the following times: (a) when all of the work called for in the contract has been completed; (b) when all of the work to be done at the job site has been completed if the contract calls for work at

more than one job site; or (c) when that part of the work done at a job site has been put to its intended use by any person or organization other than another contractor or subcontractor working on the same project. Any work that may need service, maintenance, correction, repair, or enhancement, but which is otherwise complete, will be treated as completed. The standard CGL policy does not define the term "abandoned."

While it is generally simple to ascertain when the insured has "completed" its work under a construction contract, a problem arises when the insured ceases its work under the contract but the work is ultimately completed by another contractor. This issue appears to be one that few courts have addressed. In *Clarendon America Insurance Co. v. General Security Indemnity Co. of Arizona*, 193 Cal.Rptr.3d 1 (Cal. Ct. App. 2011), the insured, a general contractor, entered into a written construction contract with the claimants to construct a custom single-family home. The contract provided that the insured would perform all of the work necessary to demolish the existing residence and to construct and complete the improvements in accordance with the plans and specifications. 124 Cal.Rptr.3d at 2–3. The contract additionally required the insured to record a Notice of Completion and to ensure that the claimants were able to "beneficially occupy" the entire property before the insured's work would be deemed completed. Prior to the completion of the work, the claimants terminated their contract with the insured. The residence was not completed when the contract was terminated. Construction of the residence was completed by a third-party, without the insured's participation, and a temporary Certificate of Occupancy was ultimately issued. *Id.*

Following the completion of construction, the claimants filed suit against the insured, alleging the presence of construction defects and/or deficiencies in the residence. The claimants alleged that these defects caused property damage to the interior and exterior of the residence. The claimants also sued the general contractor who was hired to complete construction of the residence after the claimants terminated their contract with the insured. The insured tendered its defense and indemnity to its liability carrier. Clarendon America Insurance Company ("Clarendon") accepted the insured's tender and agreed to defend the insured from the underlying construction defect action. *Id.* at 3.

Clarendon then tendered the insured's defense and indemnity to a co-primary carrier, General Security Indemnity Company of Arizona ("General Security"). General Security initially accepted the tender but then withdrew its defense of the insured on the basis that the insured failed to complete the work called for under the construction contact with the claimants and, therefore, the products-completed operations hazard clause was not triggered. Because the clause was not triggered, General Security argued that the Damage to Property J(5) and J(6) exclusions barred coverage for the lawsuit. Following a settlement with the claimants, Clarendon filed suit against General Security, seeking contribution for the amounts Clarendon paid to defend and indemnify the insured. *Id.*

Clarendon argued that General Security's disclaimer of coverage was inappropriate because the insured's work was finished for purposes of the products-completed operations hazard provision. Clarendon specifically contended that the insured's work should be deemed completed because it was undisputed that a temporary Certificate of Occupancy was issued for the residence, at which time the residence was put to its intended use by the claimants. Clarendon therefore, relying on the CGL Policy's definition of "products-completed operations hazard" third option for "completed" work, argued that it was logical to conclude that the insured's work was "put to its intended use" on the date the Certificate of Occupancy was issued. *Id.* at 7–8.

The court rejected Clarendon's argument. The court held that Paragraph 2(c) of the CGL policy's definition for the products-completed operations hazard "does not suggest a potential for coverage under the circumstances of this case." *Id.* at 8. This paragraph specifies that the insured's work is completed only when the insured's work was put to its intended use by any person or organization *other than another contractor or subcontractor working on the same project.* The undisputed facts of the case established that the insured's unfinished work was put to use by another contractor. The court explained that by "the time the [claimants] put their home to its intended use as a residence, it was no longer [the insured's] work." *Id.* In sum, the insured's unfinished work "was never put to its intended use by any person or organization other than the subsequent contractor." *Id.* The *Clarendon* court therefore concluded that the insured's work was not completed. *Id.* Unless the insured's work was abandoned, as discussed further below, the products-completed operations hazard was not triggered in this case.

As previously indicated, the standard CGL policy does not define the term "abandoned." The issue of when the insured's work is "abandoned" for purposes of the products-completed operations hazard provision is also one of limited jurisprudence. The case of *Mid-Continent Casualty Co. v. Basdeo*, 742 F.Supp.2d 1293 (S.D. Fla. 2010)

is instructive in this sparse legal landscape. In *Basdeo*, the Southgate Gardens Condominium Association (the "Association") hired the insured, a general contractor, to repair hurricane damage. The Association ultimately fired the insured, citing numerous issues with the insured's quality of work and alleged property damage resulting from the defective work. A year after the insured's termination, the Association filed suit against the insured, alleging negligence, breach of contract, and conversion. The insured tendered its defense and indemnity to its liability carrier. The insurance carrier subsequently filed a declaratory judgment, seeking a declaration that it did not owe a duty to defend or indemnify its insured. *Id.* at 1302.

In pertinent part, the insurer argued that the Damage to Property J(5) and J(6) Exclusions barred coverage for the property damage alleged in the Association's lawsuit. The parties agreed that the insured did not complete its work under the construction contract but disagreed as to whether the work was abandoned by the insured. The court first noted that the "fact that [the insured] did not complete its work does not necessarily mean that the [insured] did not abandon its work." *Id.* at 1345. The court ultimately determined that the issue of whether the insured abandoned its work could not be determined as a matter of law in *the particular case* due to conflicting evidence.

The court specified that the only evidence proffered by the insurer in support of its argument that the insured did not abandon its work was a letter from the Association to Southgate. This letter did not indicate that the Association fired the insured for abandoning the construction project. *Id.* The court explained that the letter "did not purport to set forth an exhaustive list of why [the Association] decided to terminate [the insured]" and that there was evidence supporting abandonment. Specifically, there was deposition testimony indicating that the Association members did not see the insured at the construction site for months prior to termination. Due to this conflicting evidence, the court denied the insurer's motion for summary judgment. *Id.* The *Basdeo* court's holding suggests, however, that if an insured was fired for reasons *other than* abandoning its work on the construction project, the insured's work would not be deemed "abandoned" under a CGL Policy and the Damage to Property J(5) and J(6) would therefore apply to bar coverage.

The *Clarendon* case is also instructive on the issue of abandonment. Clarendon additionally argued in its lawsuit against General Security that the insured abandoned its work for the claimants. The court indicated that the "term 'abandon' is traditionally used where 'both sides to a contract expressly announce their intention to abandon it, releasing both sides from their respective duties under the contract.'" *Clarendon*, 124 Cal.Rptr.3d at 6 (quoting *Amelco Elec. v. City of Thousand Oaks*, 27 Cal.4th 228, 253 (Cal. 2002)). The court additionally noted that "abandonment in the construction context also results from the aggregation of numerous changes to the contract over time." *Id.*

The court ultimately concluded that the insured did not abandon its work for the claimants because there was no evidence in the record establishing that either party intended to abandon the contract at the time the claimants terminated the insured from the construction project. Instead, the claimants expressly retained their rights under the construction contract and clearly stated that the insured's work was incomplete at the time of termination. In addition, there was no evidence that an excessive number of changes were made to the insureds scope of work, which ultimately resulted in the insured abandoning the work contemplated under the construction contract. *Id.*

The *Clarendon* case, therefore, suggests that work is not abandoned for purposes of the products-completed operations hazard unless both parties to the contract agree to release each other from all obligations under the contract. In the alternative, the *Clarendon* court concluded that work could also be deemed abandoned if multiple changes to the intended scope of work have resulted in the insured intentionally abandoning its work under the contract. Based on the above-referenced cases, it would appear that work is *not* abandoned if either party intends to enforce its rights and/or obligations under the contract. Accordingly, an insured's unilateral but justified termination of a contract may not qualify as abandonment as long as the insured intends to enforce its rights under the contract.

The issue of whether a insured's work is completed or abandoned for purposes of the products-completed operations hazard can determine whether a liability insurer has the duty to defend and indemnify its insured. Of note, if the products-completed operations hazard provision is not triggered because the insured did not complete or abandon its work under a contract, the Damage to Property J(5) and J(6) exclusions likely preclude coverage for the insured. These exclusions bar coverage not only for property damage to the insured's work, but also for property damage to property upon which the insured was working at the time of damage, and to any property which needs to be repaired or replaced because the insured's work was defectively performed on it. This issue is accord-

ingly one with a significant impact on coverage for a claim against a contractor.

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Recent Cases of Interest

Second Circuit

Bad Faith/Medical Professionals (NY)

Having received an answer from the New York Court of Appeals last month with respect to a certified question, the Second Circuit has entered an order in *Haar v. Nationwide Mutual Fire Ins. Co.*, No. 18-128 (2nd Cir. Dec. 17, 2019) declaring that a New York District Court did not err in refusing to find that Public Health Law Section 230(11)(b) creates any private right of action for bad faith complaints by medical professionals to New York's Department of Health's Office of Professional Misconduct.

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Fourth Circuit

Jurisdiction/Declaratory Judgment Actions

***Trustgard Ins. Co. v. Collins*, 942 F.3d 195 (4th Cir. Nov. 5, 2019)**

The U.S. Court of Appeals for the Fourth Circuit vacated and remanded a federal district court's decision favoring the insurer in a declaratory judgment action. The insurance coverage declaratory judgment action before the Fourth Circuit concerned whether an MCS-90 endorsement attached to an insurance policy required the insurer to indemnify the insured against any judgment that might result from the pending state proceeding. The federal district court held that the insurer, Trustgard Insurance Company ("Trustgard"), had no duty to indemnify the insured. However, the Fourth Circuit vacated the district court's decision, holding that the district court had abused its discretion by deciding the duty-to-indemnify issue before the resolution of the related state court proceeding.

In the underlying case, a passenger sustained injuries after the driver rear-ended a car trailer towed by a tow truck. The passenger sued multiple parties in a South Carolina Court of Common Pleas, including the insured who owned the Interstate Commerce Commission number that appeared on the tow truck. In the declaratory judgment action, the Fourth Circuit addressed two legal issues: (1) whether the court had Article III jurisdiction to hear the declaratory judgment action; and (2) whether the district court should have exercised its jurisdiction in the case. Regarding the Article III jurisdiction issue, the Fourth Circuit, applying justiciability principles, found that Trustgard's alleged injury constituted a hypothetical and contingent injury because whether Trustgard would need to pay any judgment against the insured depended on the result of the state proceeding. As such, the Fourth Circuit concluded that any declaratory judgment regarding the duty to indemnify issued by the court before the resolution of the state proceedings would serve as an advisory opinion, which violates the Article III jurisdiction principles. Notably, the Fourth Circuit stated that it would not rule on the constitutionality of exercising jurisdiction in declaratory judgment actions dealing solely with the duty to indemnify. Regarding the abuse of discretion issue, the court applied the abstention doctrine and the four Nautilus factors and concluded that attempting to determine Trustgard's duty to indemnify would cause unnecessary entanglement with the underlying state suit. The Fourth Circuit reasoned that the federal district court had to analyze the undetermined facts involved in the plaintiff's underlying state law claims to make determinations regarding vicarious liability, the absence of an owner-operator agreement, and the insured's status as a motor carrier—thereby causing the federal district court to entangle itself with the underlying state court issues and render a decision on the merits. The Fourth Circuit concluded that the federal district court abused its discretion because the court issued a decision on the merits of the underlying liability claims when the federal court should have abstained. Accordingly, the

Fourth Circuit held that the federal district court abused its discretion by assuming jurisdiction under the Declaratory Judgment Act.

Victoria Pretlow

Hancock Daniel

Richmond, Virginia

Fifth Circuit

Absolute Pollution Exclusion (TX)

The Fifth Circuit has sustained a lower court's declaration that liability claims arising out of an unplanned discharge of "rock fines" from the insured's quarry operations were subject to an absolute pollution exclusion in an umbrella policy. The dispute in *Eastern Concrete Materials Inc. v. ACE American Ins. Co.*, No. 18-11043 (5th Cir. Jan. 17, 2020) arose out of an incident in which mineral debris from blasting operations at the insured's stone quarry in New Jersey had inadvertently been discharged into adjoining creeks as a result of the insured's effort to avoid flooding in the face of severe rainstorms, resulting in clean up directives from the New Jersey Department of Environmental Protection. Despite the insured's argument that the Fifth Circuit in Texas courts lacked jurisdiction over it, the Court of Appeals concluded that it did, citing the fact that the policy had been procured in Texas and that Eastern Concrete had sufficient juridical contacts with Texas to sustain a claim of jurisdiction. The Fifth Circuit further concluded that Texas law had the more significant relationship to the case and should control the availability of coverage. Applying Texas law, the Fifth Circuit ruled that rock fines are a "contaminant" subject to this exclusion notwithstanding Eastern Concrete's contention that rock fines are simply small particles of rock that are neither inherently dangerous or contaminants. While conceding that the New Jersey EP was not claiming that the release of rock fines caused any threat of harm to drinking water or local water supplies, the Fifth Circuit concluded that their release nonetheless constituted a discharge of "contaminants " since their presence in water supplies might change the flow and contours of the stream including areas used for trout spawning and would affect the available food sources for fish and other species.

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Sixth Circuit

First Party/ACV/Policy Interpretation (OH)

The Sixth Circuit has ruled in *Michelson v. Liberty Ins. Corp.*, No. 19-3035 (6th Cir. Jan. 6, 2020) that a homeowner could not reasonably interpret an Actual Cash Value endorsement to his policy as creating additional coverage for damage to his roof from a windstorm. In rejecting the insured's effort to bring a class action against Liberty for its alleged fraud in inducing Ohio policyholders to purchase this coverage with a LibertyGuard endorsement, the Sixth Circuit agreed with the District Court that this endorsement sets forth an ACV exception to the general rule of replacement cost coverage for first party losses involving roof damage caused by hail and wind.

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Eighth Circuit

First Party/Collapse/"Building Decay" (MO)

The U.S. Court of Appeals for the Eighth Circuit has ruled in *Westchester Surplus Lines Ins. Co. v. Interstate Underground Warehouse & Storage, Inc.*, No. 18-3448 (8th Cir. Jan. 3, 2020) has ruled that a commercial property insurer did not owe coverage for losses due to the insured's underground storage facilities as the result of "dome-outs" that caused these former limestone mine shafts to collapse. Despite the insured's argument that Westchester Fire that this loss was due to collapse of a building due to "decay," the court found that the insured's installation of reinforcing bolts into the "rubble zone" above the natural ceiling of the mine shafts did not make them part of the insured "building." Because the decay that caused the "dome outs" occurred in the rubble zone, the Eighth Circuit therefore concluded that it was not "building decay."

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Tenth Circuit

Auto/Insured (CO)

The Tenth Circuit has ruled *in Chavez v. Arizona Automobile Ins. Co.*, No. 18-1473 (10th Cir. Jan. 17, 2020) that a Colorado District Court properly dismissed an accident victim's effort to enforce a default judgment against an auto insurer where there was no evidence that the driver of the insured vehicle was a permissive user. As with the Colorado District Court, the Tenth Circuit ruled that the mere statement of the driver's name did not trigger a duty to defend since it did not also include an allegation that she was operating the vehicle with the insured's permission. The court noted that the underlying Complaint did not even include the named insured's address, which might have put the insurer on notice as to which policy might be at issue.

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Eleventh Circuit

RICO/Fraud/Extortion

The Eleventh Circuit has affirmed a Florida District Court's dismissal of RICO claims that various auto repair shops brought against seven auto insurers alleging that the carriers' "direct repair programs" fraudulently forced the garages to accept below market value for their work. In *Crawford' Auto Center, Inc. v. State Farm Mut. Automobile Ins. Co.*, No. 17-12583 (11th Cir. Dec. 20, 2019), the court ruled that the plaintiffs' "vague allusions" failed to satisfy the elements for a wire fraud claim to support a RICO action, nor was it an action for "extortion."

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Alabama

Discovery/"At Issue" Doctrine

The Alabama Supreme Court has ruled that an insured does not waive the privilege attached to its communications with defense counsel by bringing an action to obtain reimbursement for a settlement. While agreeing that the insured has the burden of establishing the reasonableness of the settlement that it negotiated, the court declared in *Ex parte Dow Corning Alabama, Inc.*, 1171118 (Ala. Nov. 27, 2019) that the reasonableness of this agreement could be established without compelling the disclosure of the contents of privileged communications in keeping with prior cases involving disputes over the reasonableness of attorney's fees as well as out-of-state authority on this specific issue.

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California

Coverage B/"Malicious Prosecution"

The California Court of Appeal has ruled that a "Walker Process" claim that the insured fraudulently procured a patent from the U.S. Patent and Trademark Office and used that patent in an effort to monopolize markets was not a covered claim for "malicious prosecution." Despite the insured's argument that the Ninth Circuit's ruling in Lunsford supported a finding that the term "malicious prosecution" was ambiguous under California law, the court ruled in *Travelers Property Casualty Company of America v. KLA-Tencor Corp.*, HO44890 (Cal. App. January 16, 2020) (unpublished) that malicious prosecution can only occur in the context of legal proceedings whereas a "Walker Process" claim arises from fraud on the PTO, not a court. Since neither the fraud element nor the use element of a "Walker Process" claim necessarily involves legal proceedings, the court declined to extend "malicious prosecution coverage to such claims.

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Colorado

Jurisdiction

Magistrate Tafoya has issued a Report in *Philadelphia Ind. Co. v. U.S. Olympic Committee*, No. 19-12131 (D. Colo. Jan. 28, 2020) recommending that a liability insurer's effort to obtain a declaration that it does not owe coverage for claims arising out of Doctor Larry Nassr's sexual molestation of young athletes because the court cannot exercise federal subject matter jurisdiction in this case because

federally charted corporations such as the U.S.O.C. have national citizenship but are not citizens of any individual states.

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Connecticut

Construction/"Collapse" Occurrence

In *Karas v. Liberty Ins. Corp.*, SC 20149 (Conn. Nov. 12, 2019) the court held that "collapse" does not occur until a building is in imminent danger of falling down and therefore unsafe for its intended purpose; later policies requiring abrupt collapses do not apply to gradual deterioration of insured's concrete foundation.

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Delaware

"Accident"/Intended Injury Exclusion

The Delaware Supreme Court has ruled that a lower court erred in finding that the question of whether an assault was an "accident" should be judged from the viewpoint of the victim, rather than the insured. In any event, the court ruled in *USAA Cas. Ins. Co. v. Carr*, No. 273 (Del. Jan. 29, 2020) that coverage would have been excluded in light of language in the policy negating coverage for "bodily injury "which is reasonably expected or intended by any insured even if the resulting bodily injury . . . is of a different kind, quality[,] or degree than initially expected or intended."

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Florida

Procedure

The Florida District Court of Appeal has ruled in *Rodriguez v. Avatar Property & Cas. Ins. Co.*, Case No. 2d 18-65 (Fla. App. Jan. 15, 2020) that a trial court erred in granting a homeowner's insurer's motion to dismiss a property owner's water damage claim where the 37-page affidavit signed by the insurer's property adjuster included conclusions of law that were outside the competency of the signatory.

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Guaranty Associations/Fee Awards

The Florida District Court of Appeal has ruled that a trial court erred in awarding fees to a homeowner in a first party dispute with the state Guaranty Association. In *Florida Insurance Guaranty Assoc. v. Rubin*, No. 4D18-3147 (Fla. DCA4 Jan. 29, 2020), the court ruled that FIGA was not liable for attorney's fees because it had never denied coverage for the claim. The Fourth District ruled that mere delay in paying a claim was not the same as denying it and pointed to Section 631.70, Florida Statutes (2010), which limits the scope of section 627.428, Florida Statutes (2010), and provides that section 627.428 shall not be applicable to any claim presented . . . ." §631.70, Fla. Stat. (2010). Instead, a prevailing party is entitled to recover attorney's fees only "when the association denies by affirmative action, other than delay, a covered claim or a portion thereof."

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Idaho

First Party/Water Damage/Anti-Concurrent Causation

The Idaho Supreme Court has ruled that a trial court did not err in ruling that a property insurer did not owe coverage for damage to the insured's underground fuel tanks as the damage resulted from an excluded peril (water). In *ABK, LLC v. Century Surety Ins. Co.*, No. 46430 (Idaho Dec. 23, 2019), the court ruled that the loss resulted from surface water that had melted from snow on the ground and that this excluded cause applied in light of the policy's anti-concurrent causation clause. Additionally, the Supreme Court held that a "weather conditions" clause applied because heavy snow had caused the snow melt that puddled on the grounds and melted into the ground, infiltrating the insured's storage tanks. Having ruled that

the underlying loss was not covered, the Supreme Court also sustained the lower court's dismissal of the insured's bad faith claims against Mid-Century.

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Illinois

Auto/Anti-Stacking

The Illinois Supreme Court has reversed a ruling of the Appellate Court that "anti-stacking" language in an automobile insurance policy was ambiguous. In *Hess v. Estate of Klamm*, 2020 IL 126649 (Ill. Jan. 24, 2020), the state Supreme Court refused to find that multiple liability limits were triggered pursuant to multiple vehicles that were insured under the policy merely because the limits were stated separately as applying to these vehicles. Rather, the Supreme Court ruled that its analysis of similar language in Hobbs still applied notwithstanding the fact that the policy in this case listed the limits of liability separately on the first two pages of the declarations identifying insured vehicles. Rather, the court ruled that when the declarations are read together with the anti-stacking clause, there is no ambiguity as to the amount of bodily injury liability coverage provided under the policy.

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Construction Defect/"Occurrence"/Contribution

The Appellate Court has ruled in *Acuity Ins. Co. v. 950 West Herron Condominium Association*, 2019 IL. App. (1st) 180743 (Ill. App. Ct. Jan. 27, 2020) a trial court errored in dismissing a contribution action brought by Cincinnati Insurance against Acuity for the cost of defending construction claims against the carpentry subcontractor that both insured. In remanding the case for further proceedings, the First District ruled that the allegations in this case involved damage to the personal property of condominium owners and other areas of damage beyond the insured's faulty workmanship and were not a "natural and ordinary consequence" of the insured's faulty workmanship. The Appellate Court declared that "from the eyes of the subcontractor, the 'project' is limited to the scope of its own work, and the precise nature of any damage that might occurred as something outside of that scope is as unknown or unforeseeable as damage is something entirely outside of the construction project." The court also declared that Cincinnati had a viable claim for equitable contribution, rejecting Acuity's argument that such rights only apply where two insurance policies provide concurrent coverage for the same time period.

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Auto/"Insured"/Umbrella

The Appellate Court also ruled in *State Farm Mutual Automobile Insurance Company v. Murphy*, 2019 IL. App. (2nd) 180154 (Ill. App. Ct. Jan. 7, 2020) that an individual was not an insured under an umbrella liability policy notwithstanding the fact that he was concededly a "permissive user" of the named insured's vehicle. The Appellate Court declined to find coverage because there was no allegation in the suit that the named insured was legally responsible for the acts of the driver. As a result, the claims in question fell outside the scope of the umbrella policy's coverage for claims "brought against an insured for damages because of a loss for which the insured is legally liable ..." The court declined to find ambiguity on the basis of the "last-antecedent rule," declaring that this was a grammatical canon of construction that is resorted to by courts only when there is pre-existing ambiguity and not a basis in and of itself for finding ambiguity.

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Maryland

Cyber/Ransomware/"Direct Physical Loss"

A federal district court has ruled in *National Ink and Stitch LLC v. State Auto Property & Casualty Insurance Company*, No. 18-2138 (D. Md. Jan 23 2020) that an embroidery and screen printing business was entitled to coverage for first party losses that it suffered as the result of a December 2016 ransomware attack that prevented the insured from accessing its art files and other data on its computer servers. The had insured unsuccessfully to ransom its data and thereafter employed a security company which replaced and reinstalled the software although the programs

thereafter operated slowly and inefficiently. In requiring State Auto to provide coverage for this loss pursuant to the Business Owners Special Form Computer Coverage endorsement, Judge Gallagher ruled that the ransomware attack had caused "direct physical loss of or damage" to the insured's computer systems and that State Auto was therefore obliged to reimburse the insured for the entire cost of replacing the system. The court emphasized that the insured was not solely seeking the cost of replacing its data but rather had paid for a fully functioning computer system that was not slowed by the necessary remedial and protective measures or risk of reinfection from a dormant computer virus. Finally, the court rejected State Auto's contention that the policy requirement that there by "physical loss or damage" equated with an utter inability on the part of the computer system to function. In this case, the court found that loss of use, loss of reliability and impaired functionality demonstrated that the computer system had suffered a physical loss or damage" to it without any requirement that the system become "completely inoperable."

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Massachusetts

First Party/"Innocent" Co-Insureds

The Supreme Judicial Court of Massachusetts has ruled that a spouse is entitled to recover property insurance for a fire that was deliberately set by her husband without any involvement or knowledge on her part. In adopting the so-called "innocent co- insured" doctrine, the court emphasized in *Aquino v. United Property & Cas. Co.*, SJC-12705 (Mass. Jan. 21, 2020) that the standard fire policy mandated by G.L. c. 175 Section 99 which only avoids coverage for losses intentionally caused by "the insured." The court observed that Massachusetts recognizes the distinction between the articles "the" and "and" and that had the legislature intended to preclude recovery for innocent co-insureds, it would have drafted the statutory exclusion to apply to "an insured" rather than "the insured." The court ruled, however, that the innocent spouse was only entitled to recover half of the insured loss as that was the extent of her insurable interest in the property. Further, the court declined to impose 93A liability on the insurer, finding that its coverage position was arguably justified by "cryptic and confusing" language on this issue in its 1938 Kosior decision. The court was critical of United Property's use of exclusionary language that was inconsistent with Section 99's requirements but held that no injury had resulted from this misconduct.

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Montana

Bad Faith/Failure to Settle

The Montana Supreme Court has ruled that a liability insurer did not act in bad faith in paying its policy limit to the third party claimant even though the claimant refused to execute a release in favor of its insured. In *High Country Paving, Inc. v. United Fire & Cas. Co.*, 2019 MT 297 (Mt. Dec. 31, 2019), the court declared that a full and final release of all claims is not required for there to be a "settlement" between an injured third party and an insurer pursuant to the Montana Unfair Claims Settlement Practices Act (§33-18-201(6)). Rather, the court declared that "when it is reasonably clear that the amount required for a final settlement of all claims—including general damages reasonably shown to have been caused by the insured's conduct—exceeds policy limits, an insurer has a duty to pay policy limits to an injured third party, without conditioning such a payment on obtaining a release for its insured."

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Nebraska

"Professional Services" Exclusion

The Nebraska Supreme Court has declared that rape convictions that were wrongfully obtained by the County's cold case squad triggered EMC's "personal injury" coverage notwithstanding a policy exclusion for "professional services." In *Gage County v. Employers Mut. Cas. Co.*, 304 Neb. 926 (Neb. Jan. 31, 2020), the court declined to follow the broad definition of "professional services" that it had adopted decades ago in Marx. Instead, it looked to the fact that the umbrella and "linebacker" policies that were issued to the County as part of a suite of coverages accompanying the CGL form listed various excluded professions, none of which included law enforcement activities. The case was

therefore remanded for further findings with respect to the scope of coverage available under the EMC CGL and umbrella policies.

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New York

Bad Faith/Consequential Damages

In a first party dispute where a manufacturer of renewable bio-diesel fuel alleges that Lloyd's failure to more promptly adjust its claim increased its total losses because it could not rebuild its facility without the interim funding payments, the First Department has ruled in *Certain Underwriters at Lloyd's v. BioEnergy Development Group, LLC*, 2019 NY Slip Op 08779 (App. Div. Dec. 5, 2019) that the trial court erred in dismissing the insured's claim for consequential damages. The Appellate Division declared that, "given the purpose and particular circumstances of the property damage and business interruption policies, it was foreseeable that excessive delay would cause defendants to incur, as alleged, tens of millions of dollars in uncovered business interruption losses and attorneys' fees necessary to recover therefor."

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"Accident"

***Unitrin Auto and Home Ins. Co. v. Sullivan* (Jan. 20, 2020)**

Ciminello sued Sullivan and others for personal injuries, when he was struck by a cup tossed out a car window operated by Sullivan. Sullivan was insured under a combination homeowners and automobile policy issued by Unitrin. The homeowners personal liability part of the policy provided that Unitrin would indemnify the insured for a bodily injury damage claim caused by an "occurrence," which was defined by the policy as "an accident." The automobile liability part of the policy provided that Unitrin would pay damages for bodily injury for which any insured becomes legally responsible because of an automobile accident. The policy also contained a personal catastrophe liability endorsement which provided that Unitrin would pay that portion of the damages for bodily injury for which a covered person is legally responsible which exceeds the retained limit. Unitrin established its prima facie entitlement to judgment as a matter of law, and was entitled to judgment declaring that there was no coverage under the homeowners personal liability and automobile liability sections of the policy by submitting evidence demonstrating that the claim did not arise out of an accident but was the result of Sullivan's intentional act. In opposition, however, Ciminello raised a triable issue of fact as to whether the harm was inherent in the intentional act committed. Ciminello submitted evidence that, although Sullivan and his passenger intended to douse Ciminello with the liquid contained in the cup, there was no intent to throw the cup and strike Ciminello with it. As the instant case did not fall within the narrow class of cases in which the intentional act exclusion applied regardless of the insured's subjective intent, there was a triable issue of fact as to whether the event qualified as an "accident," as defined by the policy.

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Equitable Subrogation

***Philadelphia Ind. Ins. Co. v. Harleysville Preferred Ins. Co.* (Jan. 22, 2020)**

The plaintiff, Philadelphia Indemnity Insurance Company ("PIIC"), commenced this action against the defendant, Harleysville, for a judgment declaring certain coverage obligations in an underlying personal injury action entitled *Blake v Nashopa House Crystal Run Village, Inc*. The Blake action involved allegations that Ernest W. Blake, Jr., was injured on three separate occasions as a result of two falls that took place in May 2012 and one fall that occurred in March 2013, while he was a resident of a group home operated by the defendant in that action, Nashopa House. PIIC had issued a CGL policy effective January 1, 2012, through January 1, 2013 to Crystal Run Village, Inc., and Harleysville had issued a commercial general liability policy effective January 1, 2013, through January 1, 2014. Harleysville disclaimed coverage in the Blake action, taking the position that Philadelphia was responsible for coverage related to the third fall. After the commencement of this action, the Blake action was settled, with Harleysville contributing $300,000 toward the settlement proceeds. Philadelphia moved for summary judgment dismissing Harleysville's counterclaims and for leave to voluntarily discontinue this action on the basis that there was no longer a justiciable controversy in light of the settlement in the

Blake action. Harleysville cross-moved for leave to serve a second amended answer asserting a proposed additional counterclaim, seeking reimbursement from Philadelphia of the $300,000 Harleysville contributed to the settlement, under the doctrine of equitable subrogation. Harleysville's proposed additional counterclaim is devoid of merit as it is barred by Harleysville's voluntary payment toward the Blake action settlement.

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Construction Exclusion

***Castlepoint Ins. Co. v. Southside Manhattan View LLC* (Jan. 16, 2020)**

Castlepoint issued an insurance policy to Southside, which contains a construction exclusion for bodily injury arising out of the "[c]hange, alteration, or modification of the size of any building or structure"; "[m]ovement of any building or structure"; "[c]onstruction or erection of any new building or structure"; "[d]emolition of any building or structure"; or "[c]onstruction, demolition, movement of any load-bearing wall or any modification to the structure of any load[-]bearing wall." The exclusion expressly provides that it "applies to any work performed as part of or in connection with any of the foregoing [enumerated operations]," and "applies regardless of whether the described operations are ongoing, completed or in any other stage when the loss occurs." DiSimone alleged in that working on sprinklers at the subject premises as part of a renovation project, he fell off a ladder after coming in contact with live, uninsulated electrical wires. Castlepoint disclaimed any duty to defend or indemnify Southside in the underlying action, citing the construction exclusion in the policy. An insurance policy, as with any written contract, must be accorded [its] plain and ordinary meaning. Policy exclusions are subject to strict construction and must be read narrowly, and any ambiguities in the insurance policy are to be construed against the insurer. However, unambiguous provisions of insurance contracts will be given their plain and ordinary meaning. When an insurer seeks to disclaim coverage on the … basis of an exclusion, … the insurer will be required to provide a defense unless it can demonstrate that the allegations of the complaint cast that pleading solely and entirely within the policy exclusions, and, further, that the allegations, in toto, are subject to no other interpretation. By this standard, Castlepoint has met its prima facie burden of demonstrating that DiSimone's work installing or repairing sprinklers was "in connection" with the operations enumerated in the construction exclusion.

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Auto/ "Occupying"

***Utica Mutual Assurance Co. v. Steward* (Jan. 15, 2020)**

On August 24, 2016, Steward drove a tractor-trailer owned by his employer and insured by Utica to a construction job site in Brooklyn. Upon arrival at the job site, Steward unloaded the trailer, parked the vehicle approximately one block away from the site, and then returned to the job site to work for the day as a construction laborer. At the end of the workday, Steward was instructed to retrieve the tractor-trailer so that it could be reloaded for return transport. In preparation, Steward proceeded to the rear of the trailer to retrieve certain items that he and another employee had stored on the flatbed of the trailer during the day. Steward stood with his right leg on a Moffett ramp which was attached to the tractor-trailer and reached into the trailer bed to retrieve such items. As he was stepping down from the ramp with his left leg, a minivan drove past the construction flag men and struck Steward from behind, injuring him. The minivan that hit Steward had minimal insurance coverage, and Steward filed a Request for SUM Arbitration seeking coverage under the New York Supplementary Uninsured/Underinsured Motorists ("SUM") Endorsement of his employer's Utica Mutual commercial automobile liability insurance policy. The question for the court, in the petition to stay arbitration, is whether the Steward was an "occupant" of the vehicle. The SUM endorsement in the petitioner's policy, consistent with the statutory requirement, defines "occupying" as "in, upon, entering into, or exiting from a motor vehicle." The court found that he was "upon" the tractor-trailer and therefore, an occupant. Steward's testimony established that at the time of the accident, he had stepped upon the Moffet ramp which was attached to the tractor-trailer, and that he was struck by the minivan while his right leg was still on the ramp, and while he was stepping down with his left leg. Thus, although Steward had been away from the tractor-trailer during the workday, his testimony established

that at the time of the accident, he was in physical contact with the vehicle, such that he was "occupying" it.

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Ohio

Settlements/Liens

The Ohio Supreme Court has ruled that an auto insurer who settles a personal-injury claim with an accident victim does not have a duty to distribute a portion of the settlement proceeds to the victim's former lawyer pursuant to a charging lien. In *Kisling, Nestico & Redick v. Progressive Max Ins. Co.*, 2020-Ohio-82 (Ohio Jan. 16, 2020), the court declared that an action to enforce a charging lien is an in rem proceeding against a particular fund and that when a matter is resolved by settlement, the fund comes into being at the time the settlement is paid. A discharged law firm cannot call upon the equitable powers of the court to enforce a charging lien against a tortfeasor's insurer when no court action was initiated on behalf of the victim and an out-of-court settlement was paid to the victim. The court concluded therefore that the discharged law firm's remedy was to proceed against its former client for payment.

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Pennsylvania

Releases/Third Party Beneficiaries

The Pennsylvania Supreme Court has opened the way for construction defect claims against a building contractor's insolvent liability insurer arising out of problems with the U Conn campus. Whereas a trial court had ruled that that Reliance was a third party beneficiary of a 2016 settlement that the State entered into with Suffolk Contraction that released both the Defendants "and their respective Insurers," the state Supreme Court ruled in *Suffolk Construction Corp. v. Reliance Ins. Co.*, J-119-2019 (Pa. Dec. 17, 2019) that "at best, the language is ambiguous as to whether Suffolk released its own insurers, including Reliance, from providing insurance coverage for claims related to the Project." Having concluded that the language of the Release was ambiguous, the Supreme Court declined to reach the issue of whether Reliance was a third party beneficiary of its insured's release with the State of Connecticut.

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Virginia

Auto/"Use"

The Virginia Supreme Court has ruled that an assault of a special needs student by a fellow student on the insured's school bus did not trigger State Farm's obligation to pay UIM benefits because the assault did not arise out of the "use" of an insured vehicle. In *Corriveau v. State Farm Mut. Auto Ins. Co.*, No. 181533 (Va. Dec. 19, 2019), the court ruled that the bus was merely the "situs" of the assault and that this use was wholly separate from the use of the bus as a means of transportation.

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